PRIVATE MEDICAL INSURANCE SUPPLEMENT

State Form 51309 (R3 / 1-09) / BCD 0086
Division of Disability and Rehabilitative Services

First Steps

Effective February 01, 2009.

To be completed for all children who are covered by private health insurance.

Attach a copy of the front and back of the insurance card.

Name of child (*last, first, middle initial*)		Date of birth (*month, day, year*)
Child ID		County
Name of Service Coordinator	Telephone number ( )	Fax number ( )

INSURANCE INFORMATION

Name of insurance carrier	
Date coverage started (*month, day, year*)	Date coverage ended (*month, day, year*)
Group name	If the plan has a GROUP number, you must have a member number / ID. You may or may not have a Group name.
Group number	
Policy / member ID	If the plan has a POLICY ID, you may or may not have a group name or number

Policy billing order (*check one, please complete an additional form for a secondary insurance*)

☐ Primary ☐ Secondary ☐ Tertiary ☐ Unknown

Type of insurance (*MUST CHOOSE AT LEAST ONE*)

- ☐ Consolidated Omnibus Budget Reconciliation Act (COBRA)
- ☐ Disability
- ☐ Disability Benefits
- ☐ Exclusive Provider Organization
- ☐ Group Policy
- ☐ Health Maintenance Organization (HMO)
- ☐ Individual Policy
- ☐ Medicaid
- ☐ Personal
- ☐ Personal Payment (*cash - no insurance*)
- ☐ Point of Service
- ☐ Preferred Provider Organization (PPO)
- ☐ Other: As indicated on page two (2) of this form

Employee Retirement Income Security Act (ERISA) *(MUST CHECK ONE)*

- ☐ ERISA or Self-Insured
- ☐ Non-ERISA or Fully Insured
- ☐ Exceptions (State or University Employee)

POLICY HOLDER INFORMATION (*family subscriber*)

Name of policy holder (*last, first, middle initial*)		Telephone number ( )
Relationship to child (*check one*) ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Other: _____		Employer tax ID
Address (*number and street*)		
City	State	ZIP code
Date of birth (*month, day, year*)	Social Security number of policy holder	

The information I have provided is complete and correct to the best of my knowledge. I will notify the First Steps Service Coordinator if there are any changes in my insurance or insurance coverage.

Signature of parent	Date (*month, day, year*)
Signature of Intake / Service Coordinator	Date (*month, day, year*)

DISTRIBUTION: Original - SPOE EI file; Copy - Parent, Service Coordinator

COMPLETE LISTING FOR TYPE OF INSURANCE:

If OTHER is checked on the front page of this form, please indicate which insurance type applies toward coverage.

- ☐ Medicare Secondary, End-Stage Renal Disease Beneficiary in the 12 month coordination period
- ☐ Medicare Secondary, Working Aged Beneficiary or Spouse with Employer Group Health Plan
- ☐ Medicare Secondary, No-fault Insurance including Auto is Primary
- ☐ Medicare Secondary, Worker's Compensation
- ☐ Medicare Secondary, Public Health Service (PHS) or other Federal Agency
- ☐ Medicare Secondary, Black Lung
- ☐ Medicare Secondary, Veteran's Administration
- ☐ Medicare Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- ☐ Medicare Secondary, Other Liability Insurance is Primary
- ☐ Auto Insurance Policy
- ☐ Commercial
- ☐ Medicare Conditionally Primary
- ☐ Health Maintenance Organization (HMO) - Medicare Risk
- ☐ Special Low Income Medicare Beneficiary
- ☐ Indemnity
- ☐ Long Term Care
- ☐ Long Term Policy
- ☐ Life Insurance
- ☐ Litigation
- ☐ Medicare Part A
- ☐ Medicare Part B
- ☐ Medigap Part A
- ☐ Medigap Part B
- ☐ Medicare Primary
- ☐ Other
- ☐ Property Insurance - Personal
- ☐ Qualified Medicare Beneficiary
- ☐ Property Insurance - Real
- ☐ Supplemental Policy
- ☐ Tax Equity Fiscal Responsibility Act (TEFRA)
- ☐ Workers Compensation
- ☐ Wrap Up Policy